Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
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2:30 PM or Upon Adjournment of Session

Room 4203

(Diane Van Maren, Consultant)

Item	*Description*
4260	**Department of Health Services—*Selected Medi-Cal Issues***

Note: Only those items listed in today's agenda will be heard today. The Medi-Cal Program will be discussed again as **noted in the Senate File.** Thank you.

Note: Today's Hand Out package primarily consists of the Administration's proposed trailer bill language. If you do not obtain a copy of this package today (limited copies available), please obtain copies of the Administration's language by contacting either the DHS or DOF directly (it is their language). Thank you.

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I. 4260 Department of Health Services—*Medi-Cal Program*

A. BACKGROUND

Purpose and Summary of Governor's Proposed Budget on Medi-Cal

The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. **It is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents; (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness (many of whom were once middle class); and (3) a wrap-around coverage for low-income Medicare recipients.**

Presently about 6.5 million people, or one in five Californians, are eligible for Medi-Cal in any given month. **According to the DOF, Medi-Cal provides health insurance coverage to 17.3 percent of all Californians.**

The Governor's budget for Medi-Cal proposes expenditures of $27.7 billion ($7 billion General Fund, $3 billion Reimbursements from Counties). This reflects a *net* decrease of almost $3.6 billion (General Fund), or 33.9 percent less than the revised 2002-03 budget.

This significant net reduction is attributable to several key factors, including the following:

- Transfers 15 percent of Medi-Cal benefit costs to the counties, along with a revenue stream, for savings of $1.6 billion (General Fund).
- Transfers fiscal responsibility, but not policy administration, of long-term care services to the counties along with a revenue stream for savings of $1.4 billion (General Fund).
- Reduces Medi-Cal and non-Medi-Cal provider rates by a total of 15 percent for savings of $1.427 billion ($720.5 million General Fund). The savings level assumes adoption of trailer bill language to enact a ten percent reduction as of April 1, 2003, and an additional 5 percent reduction (for a total of 15 percent) by July 1, 2003.
- Proposes legislation to rescind the 1931(b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) and to reinstate the "100-hour a month work limit" for savings of $236 million ($118 million General Fund). These savings estimates assume that about 293,000 low-income, uninsured adults will not be eligible for Medi-Cal coverage in 2003-04. According to the DHS, this number will continue to grow at a rate of 19,000 individuals per month beginning in the next fiscal year.
- Proposes legislation to rollback the extension for the Aged and Disabled Medi-Cal eligibility category from 133 percent of federal poverty to the SSI/SSP income level for savings of $127.6 million ($63.8 million General Fund). This savings estimate assumes that 48,300 aged recipients and 20,540 disabled recipients are eliminated from Medi-Cal coverage.
- Proposes legislation to reinstate the Quarterly Status Report effective April 1, 2003 and to change statute regarding the determination of Medi-Cal eligibility for savings of $170 million ($85 million General Fund).

A. BACKGROUND (Continued)

Who is Eligible for Medi-Cal ?

Generally, Medi-Cal eligibles fall into four broad categories of people: (1) aged, blind or disabled; (2) families with children; (3) children only; and (4) pregnant women. Men and women who are not elderly and do not have children or a disability *cannot* qualify for Medi-Cal, no matter how low-income they are.

Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category.

States are *required* to include certain types of individuals or eligibility groups under their Medicaid state plans *and* they *may* include others—at the state's option.

With respect to federal law, the Medicaid Program is divided into three divisions: (1) Mandatory Categorically Needy, (2) Optional Categorically Needy, and (3) Medically Needy.

Federally required individuals (i.e., Mandatory Categorically Needy) include the following:

- ***SSI/SSP Cash Grants:*** These are Supplemental Security Income/State Supplemental Payment (SSI/SSP) recipients.
- ***Medicare Cost Sharing Programs:*** This means that Medi-Cal pays for **all or some** portion of an individual's federal Medicare coverage/premium. This includes all or partial payment for Medicare Part A (hospitalization), Medicare Part A (deductible), Medicare Part A (coinsurance), Medicare Part B (doctor visits, laboratory work, and more), Qualified Medi-Cal Beneficiary Program, Specified Low-Income Medicaid Beneficiary Program, and Qualified Individuals Program.
- ***Miscellaneous Disabled:*** This includes small categories of individuals who are (1) former SSI recipients who lost SSI due to a COLA change (i.e., Pickle Program), (2) considered part of the Disabled Adult Child Program, or (3) considered part of the Disabled Widow(ers) Program.
- **CalWORKS Cash Grants:** These are CalWORKS-linked individuals (women and their dependent children).
- ***Transitional Medi-Cal:*** Covers those discontinued from CalWORKS or Section 1931 (b) due to increased earnings, for up to one year. California provides an additional year (for a total of two years) at the state's option. The Administration is proposing to eliminate the second year in their proposed budget.
- ***Section 1931 (b) Individuals (Up to Poverty):*** These are families who are ***not*** receiving case-assistance **but who otherwise meet the state's CalWORKS eligibility requirements in effect on July 16, 1996** (date the federal Welfare Reform Act became law). These are low-

income families where the children are deprived by the absence, death, incapacity or unemployment of a parent. **Federal law allows for the "Section 1931 (b)" income standard to be as low as that in the former Aid to Families with Dependent Children (AFDC) state plan as of May 1, 1998. California currently sets our 1931 (b) standard at 100 percent of poverty. The Administration is proposing to lower this to the CalWORKS level (about 61 percent of poverty for applicants and 155 percent for recipients).**

- ***133 Percent of Poverty:*** These are **children ages 1 to 6 years** in families with incomes up to 133 percent of poverty.
- ***100 Percent of Poverty:*** These are **children ages 6 to 19 years** of age in families with incomes up to 100 percent of poverty.
- ***Children in Foster Care/Adoption:*** These are children who are in Foster Care or are adopted under the federal Title IV-E program.
- ***Pregnant Women & Infants up to 200 Percent of Poverty:*** These are pregnant women up to 200 percent of poverty and their infants up to the age of one year. Though federal law requires coverage up to 185 percent of poverty, **California must maintain the 200 percent** of poverty level in order to continue to receive our federal funds through Title XX--State Child Health Insurance Program (S-CHIP) (i.e., our Healthy Families Program). Federal S-CHIP law requires states to provide coverage to children in Medicaid (Medi-Cal) at the level that was provided prior to S-CHIP implementation.

States provide Medicaid coverage to the Optional Categorically Needy group as they deem appropriate. However, if a state wants to cover them, there are federal requirements associated with them. Their medical services are required to be no less in amount, duration or scope than those of the mandatory categorically needy. They share the characteristics of the mandatory categorically needy, but the eligibility criteria are somewhat more extended.

California provides coverage to the following Optional Categorically Needy groups:

- ***Aged, Blind and Disabled:*** This includes aged, blind and disabled individuals with income under 133 percent of poverty. Federal law sets the income standard at the SSI standard whereas state law (Section 14005.40 of W&I Code) provides that the income standard is set at 100 percent of poverty with an additional income disregard ($230 per individual or $310 per couple) which takes it to just under 133 percent of poverty. The Administration is proposing to roll this back in the budget year (discussed below in this agenda).
- ***Disabled Working Program at 250%:*** This program allows disable working **individuals to pay a premium to buy into full scope** (no share of cost) Medi-Cal. Eligibles must have family income below 250 percent of poverty (disregarding disability income). Federal law allows for the 250 percent income test to be based on gross income but also allows states latitude in disregarding income and property.
- ***Individuals with Developmental Disabilities Enrolled in the Home and Community Based Waiver:*** This includes individuals with developmental disabilities that meet certain criteria

(mainly at significant risk of being institutionalized). The Waiver does have an enrollment cap which was imposed by the federal CMS.

- ***Breast and Cervical Cancer Up to 200 Percent:*** This program is for uninsured women under age 65 (income below 200 percent of poverty) who are screened with breast or cervical cancer by a federal Centers for Disease Control and Prevention (CDC)-approved provider and need treatment.
- ***Individuals with TB who meet SSI:*** This includes individuals diagnosed as having TB who meet the SSI requirements for income and property. This is obviously needed for public health purposes.

The third category contained in federal law is the Medically Needy category. This is an optional federal program. **Generally, this program covers individuals who have too much income to qualify for a Mandatory or an Optional Categorically Needy group and are allowed to use the amount of their "excess income" (known as a "share-of-cost") to pay medical expenses.** Once the share-of-cost has been met, Medi-Cal will pay for the remainder of their medical expenses. **Individuals include:**

- The aged; blind; disabled (including those who are in long-term care);
- Pregnant women;
- Children up to age 21 years who are deprived by the absence, death, incapacity or unemployment of a parent; **and**
- A caretaker relative of a deprived child.

According to the DHS, if a state has a Medically Needy program, it must cover pregnant women and children under age 18 years who except for income and resources, would be Mandatory Categorically Needy. In addition, **states may choose** to cover the aged, blind, disabled, children (between 18 and 21), and caretaker relatives.

In addition to this Medically Needy category is the **Medically Indigent Program.** As noted by the DHS, this program has both a state-only as well as federal component. **It covers (1) children under age 21 years who are not deprived by the absence, death, incapacity or unemployment, (2) pregnant women with no deprived children, and (3) adults in long-term care that cannot be covered under any other program.**

A. BACKGROUND (Continued)

Summary of Caseload Information

The revised caseload for 2002-03 (current-year) of 6.5 million eligibles is 9.5 percent above the revised 2001 Budget Act level. However due to the Administration's proposed reductions in eligibility, the budget assumes a total of less than 6.3 million eligibles for 2003-04, for a *net* reduction of 209,000 eligibles, or 3.2 percent less from the revised 2002-03.

But as referenced below, if the Administration's proposed Medi-Cal eligibility changes are adopted, a total of 1.1 million individuals would lose Medi-Cal coverage in the budget year. These proposals are as follows:

- Rescinding the 1931 (b) eligibility category to eliminate about **293,000 people**;
- Reinstating the Quarterly Status Report to eliminate about **193,000 people**;
- Rolling back the Aged, Blind and Disabled Program from 133 percent to 100 percent of poverty to eliminate almost **69,000 people**;
- Establishing new standards for counties to make Medi-Cal redeterminations to eliminate about **563,000 people** in 2003-04 due to making timely redeterminations; and
- Eliminating the second-year of availability for Transitional Medi-Cal coverage to eliminate about **1,800 people** from coverage.

Major Medi-Cal Eligibility Category 2002-03 (Current Year) (LAO)	**Current Enrollees**	**Annual Benefit Cost Total Funds (Millions)**
Aged, Blind or Disabled		$13.728 Billion
• SSI/SSP	1,225,000	
• Medically Needy	254,000	
• Medically Needy—Long Term Care	69,000	
Families		$6.120 Billion
• CalWORKS	1,574,000	
• Section 1931 (b)-only (includes Medically Needy)	2,485,000	
Children & Pregnant Women		$1.201 Billion
• 200 Percent (Pregnant women & infants)	188,000	
• 133 Percent (Ages 1 to 6)	124,000	
• 100 Percent (Ages 6 through 18)	133,000	
• Medically Indigent (ages 6 to 18)	163,000	
• Medically Indigent Adults	6,000	
Emergency Only	760,000	$1.151 Billion

B. ITEMS RECOMMENDED FOR CONSENT

1. BabyCal—Administration's Proposal to Defer Outreach *(See Hand Out)*

Background and Governor's Proposal: The **Administration proposes to eliminate $6.2 million ($3.1 million General Fund)** for the BabyCal Program which educates high risk pregnant women about the importance of early and ongoing prenatal care, the consequences of smoking, drinking and drug use during the pregnancy, and the availability of programs that can help women achieve healthy birth outcomes. The Administration states that "prenatal care information is available through other public health resources."

Subcommittee Staff Recommendation: Due to the current fiscal situation, **it is recommended to adopt the Administration's proposal to eliminate funding for BabyCal and to change existing statute to have the program contingent upon annual appropriation through the Budget Act.**

2. Disproportionate Share Hospital Program Staffing

Background and Governor's Budget Proposal: The DHS administers the Disproportionate Share hospital (DSH) program that annually generates more than $2 billion of funding for California's safety net hospitals serving the uninsured, medically indigent, and low-income. DSH program funds are derived from local public hospitals and federal matching funds. No General Fund support is used for DSH.

The **budget is requesting an increase of $266,000** ($133,000 inter-governmental transfer funds and $133,000 federal funds) **to provide funding for three positions**—two Research Program Specialist I's, and a Research Program Specialist II.

The DHS states that these positions will be used to eliminate the backlog of delinquent DSH functions that are affecting the financial stability of DSH eligible safety net hospitals.

Subcommittee Staff Recommendation: These positions are needed and no General Fund augmentation is required. **No issues have been raised** by constituency groups or the Legislative Analyst's Office.

C. ITEMS FOR DISCUSSION

1. Accrual to Cash Accounting —Discussion of Potential Shift for Medi-Cal Program

Background & Description of the Accrual to Cash Accounting Option: The **Medi-Cal Program is currently budgeted on an accrual basis**. **Under this method of accounting, expenses and revenues are accounted for when they are incurred or earned.** As such, when Medi-Cal services are rendered by a provider, the cost for these services are paid out of funding for that specific budget year, even if they are received after the end of that fiscal year.

Under a *cash basis* of accounting, the expenditures and revenues are recognized when they are paid or received. Therefore, funding for Medi-Cal expenses must be included in the budget for the year in which the services were provided to the beneficiaries.

When Medi-Cal began in 1966-67 it was on an accrual accounting basis. In 1971-72, Governor Ronald Reagan switched the accounting basis to cash. The change in accounting was made, in part, to help address a budget deficit problem similar to what the state confronts today.

Medi-Cal was on a cash basis until 1991-92 when Governor Pete Wilson switched to an accrual basis. The switch by Governor Wilson was for the same reason that Governor Reagan made the switch, to address a significant budget deficit. The switch under Governor Wilson was more comprehensive, revenues and expenditures were switched to accrual based accounting. Revenues and expenditures were increased because of the switch. However, the increased revenues for the General Fund more than offset the increase in expenditures, which was a result from the changeover.

The Federal Government requires the state to maintain the Medi-Cal Program on a cash basis, whereas the State Controller's Office requires the state to maintain programs on an accrual basis.

When the state went to accrual accounting in 1991-92 bond rating agencies were concerned the state was incurring debt without an approved budget when Medi-Cal deficiencies occurred. At that time there were deficiencies nearly every year and they automatically became an obligation that Medi-Cal had to pay.

Section 16531.1 of the Government Code created the Medi-Cal Providers Interim Payment Fund for the purposes of paying Medi-Cal providers, providers of drug treatment services for HIV patients and providers of developmentally disabled services, **during any portion of a fiscal year, prior to September 1 of that year, in which a budget has not been enacted. This section also appropriates up to $1 billion from the GF and up to $1 billion from the Federal Trust Fund, in the form of loans for these purposes.**

This existing provision could be modified to include payment of Medi-Cal providers in <u>any</u> fiscal year when a deficiency in GF appropriations exists in the last quarter of that fiscal year. The loans would similarly be repaid from the next fiscal year's Medi-Cal

appropriation. In order to shift from accrual to cash, the loan authority would need to be increased to as much as $3 billion.

Changing from an accrual to cash accounting system is part of the Senate Republican's budget proposal for addressing the current fiscal shortfall.

Based on technical assistance provided by the DHS, a General Fund savings of $1.128 billion could be achieved through this accounting change. (This level of savings assumes no enactment of the Governor's proposed Realignment **and** reflects savings obtained from all departments.)

Governor's Proposed Budget: No proposal for this change has been submitted for consideration.

Subcommittee Request and Questions: The Subcommittee **has requested the DHS/DOF to respond to the following questions from a technical assistance basis.**

- **1.** Generally, what would need to occur for this transition to be implemented?
- **2.** Would trailer bill legislation be required to implement this change appropriately?
- **3.** What, if any, concerns or reservations may the Administration have in making this shift?

Budget Issue: Does the Subcommittee **want to *consider the feasibility* of shifting from accrual to cash accounting for the Medi-Cal Program?**

2. Administration's Proposed Realignment—ISSUE "A" and "B"

Governor's Proposed Budget—Summary Overall: The Governor's proposed Realignment package consists of **four components in the health and human services area (over $7.9 billion), plus a court security plan for the Trial Courts ($300 million), for total expenditures of $8.2 billion.** The proposed new dedicated Realignment **revenues would stream from an increase in the Sales Tax (one percent), an increase in Personal Income Tax (10-11 percent bracket) and an increase in the Tobacco Excise Tax ($1.10 increase).**

The Administration proposes trailer bill legislation for each of these components. At this juncture, **the language is crafted broadly** to express the Legislature's intent to enact legislation to **(1)** transfer the specified program and its non-federal share of expenditures, **(2)** maintain state oversight of said programs, and **(3)** become operative only if dedicated revenues are enacted for this purpose.

The proposal assumes that 2003-04 fiscal allocations to counties would be based on the proposed level of funding for counties for each of the programs, absent Realignment, in order to avoid program disruptions in the budget year. However for 2004-05, the

Administration assumes that a single allocation would be made to counties based on a formula to be developed through discussions. **As such, this would potentially serve as a type of "block grant" to the counties whereby the counties could conceivably shift funding across programmatic areas.**

ISSUE "2-A"—Realignment: Proposed 15 Percent Transfer of Medi-Cal Benefits

Governor's Proposed Budget: As part of the **"Healthy Families" Realignment proposal**, the Administration proposes to **shift 15 percent (non-federal share) of Medi-Cal benefit costs to the counties for a savings of $1.620 billion (General Fund).** The counties would use revenues obtained from **newly proposed tax adjustments** (i.e., increased Sales Tax, increased Excise Tax on Tobacco Products and increased upper-income bracket) to fund this share of cost.

As presently proposed the state would retain authority regarding eligibility criteria, benefits offered, reimbursement rate levels and all other policy aspects of Medi-Cal administration.

Subcommittee Staff Comment & Recommendation: In reviewing this proposal within the context of the principles established in crafting the Realignment of 1991-92, it does not appear to be a constructive fit. **Medi-Cal is a complex program which is driven by federal law and regulation, case law and legal settlement agreements, state law and regulation, and trends in overall health care such as the absence of employer-sponsored coverage, continually rising health care costs and changes in the methods of medical practice.**

An entitlement program with the complexities inherent in the Medi-Cal Program does not afford local government with the opportunity to identify innovative ways to recast the program or even to shift expenditures to more of a community- based, lower cost model of service, as was effectuated under the mental health program Realignment of 1991-92. It is very unlikely that discretion of any modicum would be granted to counties due to the need to maintain certain federal requirements, particularly the need to ensure that Medicaid (Medi-Cal) recipients receive a like level of service no matter where they live in the state (i.e., the statewideness factor).

Question also arises as to the reliability of the revenue stream to sustain a 15 percent share of Medi-Cal benefit costs even in the near term. A recent study by the federal Centers for Medicare and Medicaid Services (CMS), **as published in *Health Affairs*, shows that overall health care spending in the United States rose by 8.7 percent from 2001 to 2002.** The major contributing factors sited were the rising cost of prescription drugs, hospital care and Medicaid expenditures, particularly for the aged, blind and disabled populations.

Changes in federal Medicare policy can also significantly affect policy choices and expenditures in Medi-Cal. For example, Medi-Cal provides long-term care services and pharmacy benefits whereas Medicare does not. As such, many elderly and disabled individuals who are dually eligible for both programs obtain these benefits through Medi-Cal.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- Please briefly explain the proposal to require counties to fund 15 percent of the Medi-Cal benefit costs.

Budget Issue: Does the **Subcommittee want to reverse the Governor's Realignment proposal in order to have a level playing field to begin overall restructuring/realignment discussions**?

ISSUE "2-B"— Realignment: Long-Term Care Nursing Home Services

Governor's Proposed Budget: As part of the **"Long-Term Care" Realignment** proposal, the Administration **shifts the cost (non-federal share) of skilled nursing facility care to the counties for General Fund savings of $1.4 billion. This includes all skilled nursing facilities** (freestanding as well as distinct-part facilities), but does not include Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Federally mandated benefits such as pharmacy would remain the responsibility of the state for those eligible individuals residing in these facilities.

Subcommittee Staff Comment On Proposal: Generally, **nursing home expenditures are primarily driven by the acuity of the patient, direct care staffing needs, the existing labor market, and quality assurance standards**. **Counties will have little, if any, control over these factors.**

This component of realignment suffers the same limitations as the proposal to shift 15 percent of the share of Medi-Cal costs to the counties. It does not offer local government the opportunity to identify innovative ways to recast the program or even to shift expenditures to more of a community-based model. It simply has the counties serve in a caretaker capacity with no where to go for program expenditures, except up.

Shifting expenditures for skilled nursing care to the counties runs contrary to recent sweeping changes enacted by the Legislature to make major reforms regarding quality of care issues, direct care nursing staff to patient ratios, and restructuring options for changing the existing Medi-Cal reimbursement rate methodology. Many of these reforms would be left in mid-stream or not completed at all if expenditures are shifted. Counties could be left in the untenable position of trying to fund program expenditures with no ability to modify policy.

In addition, it is unclear how the state's implementation of the United State's Supreme Court's decision in *Olmstead v L.C.* (527 US 581 (1999)) would be affected by this realignment proposal. Under Olmstead the court ruled, among other things, that an individual with a disability has a right to live in a community setting as long as certain conditions are met.

This would include some existing residents of nursing homes. **The California Health and Human Services Agency is presently crafting an Olmstead Plan, to be provided to the Legislature by April 1, 2003, in which options for meeting Olmstead needs are to be discussed. Therefore, it would be beneficial for the Legislature to review this plan in the context of this realignment proposal.**

Subcommittee Request and Questions: The **Subcommittee has requested the DHS to respond to the following questions:**

- Please briefly explain the proposal to require counties to fund 15 percent of the Medi-Cal benefit costs.

Budget Issue: Does the Subcommittee **want to reverse the Administration's proposed Realignment proposal regarding the transfer of Long-Term Care expenditures in order to begin overall restructuring/realignment discussions**?

3. Administration's Proposed Reductions to Medi-Cal Eligibility—*ISSUES "A" to "D"*

Governor's Proposed Budget—Overall Reductions to Eligibility: **The revised caseload for 2002-03 (current-year) of 6.5 million eligibles is 9.5 percent above the revised 2001 Budget Act level. However due to the Administration's proposed reductions in eligibility, the budget assumes a total of less than 6.3 million eligibles for 2003-04, for a *net* reduction of 209,000 eligibles, or 3.2 percent less from the revised 2002-03.**

But as referenced below, if the Administration's proposed Medi-Cal eligibility changes are adopted, a total of 1.1 million individuals would lose Medi-Cal coverage in the budget year.

These proposals are as follows:

- Rescinding the 1931 (b) eligibility category to eliminate about **293,000 people**;
- Reinstating the Quarterly Status Report to eliminate about **193,000 people**;
- Rolling back the Aged, Blind and Disabled Program from 133 percent to 100 percent of poverty to eliminate almost **69,000 people**;
- Establishing new standards for counties to make Medi-Cal redeterminations to eliminate about **563,000 people** in 2003-04 due to making timely redeterminations; **and**
- Eliminating the second-year of availability for Transitional Medi-Cal coverage to eliminate about **1,800 people** from coverage.

ISSUE "3-A"—Reinstate Quarterly Status Reports & Change Determinations
(See Hand Out for Language)

Background on the QSR and SB 87, Statutes of 2000: The **Budget Act of 2000 eliminated the Quarterly Status Report (QSR) process in favor of a streamlined system whereby families are required to self report within 10-days of any change in circumstance (such as a change in income).** Elimination of the QSR reduced administrative processing, maintained the families health care coverage, and simplified Medi-Cal to conform with the Healthy Families Program, as well as employer-sponsored coverage.

Under the QSR process, families participating in Med-Cal only (non-cash aid) are required to complete a detailed form about income and other personal information ***every*** **three months (quarterly), even if there is no change in the families circumstance.** Medi-Cal coverage is discontinued if the form is not returned.

According to the DHS**, a Medi-Cal recipient has 60-days in which to return their QSR form before they are terminated from the program. The DHS also states that they would use a new "simplified" form for this purpose. The specific QSR steps are as follows:**

- **First, if a Medi-Cal recipient does not return their QSR form within 20 days, the county is required to send a "notice of action" to the home;**
- **Second, the Medi-Cal recipient then has an additional 10 days to submit the QSR form.**
- **Third, if the QSR form is still not received by the county, then the Medi-Cal recipient is placed on hold for 30-days. (In essence, if they try to obtain services using their Medi-Cal card, it will not work.) At the end of this 30-day period, the Medi-Cal recipient is terminated unless the QSR form is returned.**

As illustrated below, all "non-exempt" recipients will be required to complete 3 QSRs and 1 Annual Redetermination during a 12-month reporting cycle.

DHS Provided: Sample reporting cycle

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Month Medi-Cal granted	Start of QSR report cycle		**QSR Mail Month** (QSR mailed by 10th)	**QSR Due Month** (QSR due by 5th)		**QSR Mail Month** (QSR mailed by 10th)	**QSR Due Month** (QSR due by 5th)		**QSR Mail Month** (QSR mailed by 10th)	**QSR Due Month** (QSR due by 5th)	
Annual redetermination mailing month	Annual redetermination due month										

The DHS states that they will follow the SB 87 process (ex parte, attempted telephone contact and a Medi-Cal notice #355) for "non-exempt" recipients who return a signed but incomplete QSR. If the incomplete QSR cannot be resolved after the SB 87 process, the recipient will be sent a discontinuance notice of action. If the recipient returns the completed QSR within 30-days after discontinuance *and* continued eligibility exists, the QSR will be evaluated and the discontinuance action rescinded.

Prior to the elimination of the QSR, many Medi-Cal recipients were terminated from coverage even though they still qualified for services simply because they did not submit a QSR.

Chapter 1088, Statutes of 2000 (SB 87, Escutia), generally requires that in instances when Medi-Cal eligibility has been terminated on one basis, that a review must be conducted to determine if the individual is eligible for Medi-Cal under other circumstances. All avenues of potential Medi-Cal eligibility are to be reviewed to determine ongoing eligibility. It should be noted that under the Craig v Bonta' lawsuit, the court ruled in favor of the plaintiffs, and has, among other things, required the DHS to submit an implementation plan regarding compliance with Section 14005.37 of Welfare and Institutions Code regarding Medi-Cal eligibility redeterminations.

The Administration's proposed language would significantly erode existing statute (SB 87, Statutes of 2000) by deeming Medi-Cal recipients who fail to return the QSR as being uncooperative and automatically terminated from benefits. This aspect of the Administration's proposal goes beyond simply reinstating the QSR. In fact it would mean that SB 87 rules would not apply to individuals who fail to return the QSR form. Individuals in this category (i.e., "failed-to-return") would be considered new applicants to Medi-Cal and have to complete new eligibility forms.

Governor's Proposed Budget: The **Administration proposes legislation to reinstate the QSR effective April 1, 2003 *and* to change statute regarding the determination of Medi-Cal eligibility.** Savings of $5 million (General Fund) in 2002-03 and $85 million (General Fund) in 2003-04 are estimated for this action. **These savings estimates assume that 33,900 adults will be terminated from Medi-Cal coverage in 2002-03 and that 193,123 adults are dropped in 2003-04. With respect to the mid-year proposal, the Legislature chose to deny it and to focus on the budget year.**

Reinstatement of the QSR would achieve savings by terminating adults from Medi-Cal who are still likely eligible for Medi-Cal but simply did not return the QSR. **The majority of recipients affected by this change would be families (non-cash aid) enrolled in Medi-Cal managed care plans. It is estimated by the DHS that about 1 million people would be subject to the QSR process if reinstated as proposed.**

According to the DHS, individuals *not* affected by the proposed reinstatement of the QSR include the following:

- Women who are pregnant **and** enrolled in the Medi-Cal eligibility "pregnancy" aid codes (Women who are 1931 (b) eligible and then become pregnant **would be affected** by the QSR proposal.);
- CalWORKS-linked adults (They already have the CalWORKS paperwork requirements); **and**
- Aged, blind, and disabled Medi-Cal recipients.

Subcommittee Staff Comments: There are several concerns with this proposal. **First, these Medi-Cal recipients are very low-income wage earners—usually working people who have left CalWORKS and need medical coverage. Their circumstance is not likely going to change significantly and if it does, the recipient is required to report a change within 10 days.** In addition, county eligibility offices can and often do monitor changes in Medi-Cal recipients' earnings using the state's automated wage reporting system; therefore, program eligibility can be checked prior to a recipients annual re-determination period.

Second, individuals dropped from Medi-Cal for not returning a QSR will likely seek medical assistance at county indigent health clinics or the emergency room. Safety net hospitals would lose Medi-Cal revenues and likely have to provide coverage to more uninsured.

Third, a key concern with this proposal is its interaction with the Administration's proposal to eliminate the 1931 (b) Medi-Cal eligibility category. If a Medi-Cal recipient (adult, non-cash aid) does not return their QSR and is dropped from Medi-Cal, they likely will *not* be able to re-apply for Medi-Cal due to the elimination of the 1931 (b) category. (This issue is discussed further in item 3-B below.

Fourth, elimination of the QSR was intended to reduce over time Medi-Cal Administration costs in order to make the program more efficient and effective. If the QSR is reinstated, counties may need substantially more funding in order to re-program computer systems, train eligibility workers, and hire additional staff to process the additional paperwork.

Fifth, it would severely erode existing statute (SB 87, Statutes of 2000) by deeming Medi-Cal recipients who fail to return the QSR as being uncooperative and automatically terminated from benefits. As such, these individuals would not have their eligibility status reviewed by the county, nor would they be eligible to receive Transitional Medi-Cal Program coverage even if they would otherwise quality (low-income) for the benefits.

Sixth, 37 other states allow parents participating in Medicaid to annually renew their coverage. In fact, a federal review conducted of California in 2000 expressed grave concerns that a significant number of Medi-Cal recipients were losing coverage because the QSR was not being returned. In response to this criticism, the Davis Administration noted that it was eliminating the QSR requirement to facilitate the retention of families.

Further, there could be *unintended* consequences for children if this proposal is adopted. Many families apply to Medi-Cal as a family unit (parents and children). Subsequently, unless county computer systems are modified to distinguish between family members who are subject to the QSR and family members who are not, children could lose their Medi-Cal coverage inappropriately through a processing error.

This is a realistic concern since a federal review conducted in California in 2001 found numerous inconsistencies in the operation of Medi-Cal computer systems across counties. In addition, parents receiving a Medi-Cal termination notice may mistakenly believe that their entire family, including children, are being dropped from enrollment.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly explain the proposal.
- **2.** What are the county administrative costs for this proposal and have those expenditures been off-set from the Administration's proposed savings?
- **3.**

Budget Issue: Does the Subcommittee **want to adopt or deny the proposal?**

ISSUE "3-B"—Proposed Rescission of 1931 (b) Medi-Cal Eligibility

Background—Who are 1931 (b) Families: The Budget Act of 2000 extended eligibility for Medi-Cal to include families with income up to 100 percent of the federal poverty level.

This action was in response to a federal Welfare Reform law change (Section 1931 (b) of the Social Security Act) which enabled states to grant Medicaid eligibility to anyone who would have met the income, resource and deprivation rules (such as children with an absent, decreased, incapacitated, or unemployed parent) of the AFDC Program as it existed on July 16, 1996 (date selected by Congress).

The concept behind this federal policy was to maintain health coverage for families that leave welfare for work, eliminate the incentive to be on welfare in order to receive health care coverage, and to make health care available for working, very low-income families.

Governor's Proposed Budget: The Administration proposes legislation **to rescind the 1931 (b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) *and* to reinstate the "100-hour a month work limit".** This proposal would limit eligibility to families with incomes up to about 61 percent of poverty (annual income of $11,041 for a family of four). With respect to employment, two-parent families would become *ineligible* for Medi-Cal if the principle wage earner works *more* than 100 hours a month (about 23 hours a week), no matter their low-income level.

The proposal assumed an April 1, 2003 implementation with savings of $12.4 million ($6.2 million General Fund) in 2002-03 and **$235.9 million ($118 million General Fund) in 2003-04. These savings estimates assume that 58,578 adults will not be eligible for Medi-Cal coverage in 2002-03 and that 292,890 adults will not be eligible for Medi-Cal coverage in 2003-04. After full implementation, the DOF estimates savings of $985.1 million ($492.6 million General Fund) annually.**

With respect to the mid-year proposal, the Legislature chose to deny it and focus on the budget year.

Examples of How Medi-Cal Eligibility Would be Changed Under this Proposal: Here are examples of how Medi-Cal eligibility would be changed **and made more complex** under this proposal:

- Two-parent working families **applying** for Medi-Cal where the primary wage earner works *more* than 100-hours per month will no longer qualify for Medi-Cal at *any* income level.
- Two-parent working families applying for Medi-Cal where the primary wage earner works *less* than 100-hours per month, will be eligible for the 1931 (b) category if their incomes are under 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they would qualify for Medi-Cal under the Medically Needy category. If their income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.
- Single-parent families and those two-parent families where one is disabled can qualify for the 1931 (b) category if their incomes are below 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they qualify for the Medically Needy category. If their income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.
- Families enrolled in Medi-Cal now (recipients) who rely on the applicant income test (families with unearned income, such as disability income) will only quality for the 1931 (b) category if their incomes are under 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they qualify for the Medically Needy category. If their income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.

Subcommittee Staff Comment: As illustrated by the eligibility examples provided above, **this proposed policy change serves as a *disincentive* to work full-time, to maintain family unity, and to move off of CalWORKS.** Many families would not qualify for Medi-Cal even though they meet the low-income test because they are working more than 100-hours a month. If they lose health care coverage, they can spiral back into CalWORKS and potential poverty. If desired, the 1931 (b) eligibility category could be reduced *without* reinstating the 100 hour a month work limit.

This proposal also interacts with the Administration's proposal to reinstate the Quarterly Status Report (QSR). If an existing 1931 (b) category recipient loses Medi-Cal because they do not return their QSR, they are dropped from Medi-Cal and likely would *not* be eligible for Medi-Cal due to the elimination of the 1931 (b) category. This is particularly true for those who are working more than 100 hours a month.

This proposal would be problematic for any future extension of the Healthy Families Program (HFP) to parents because the federal CMS requires California to continue to provide Medi-Cal eligibility to 1931 (b) individuals as a condition for approving the state's HFP Waiver. As such, it is very unlikely that California could ever proceed with the Waiver in future years if the 1931 (b) eligibility is rescinded.

This proposal also affects a families eligibility for Transitional Medi-Cal services. Currently when a family loses 1931 (b) eligibility because their income goes above 100 percent of poverty, they can still potentially obtain up to two years of coverage. The purpose of this federal law for transitional services is to assist families to move into self-sufficiency. However, families in the Medically Needy category are not eligible for Transitional Medi-Cal services. Subsequently families with incomes above 61 percent of poverty who will no longer qualify for 1931 (b) but will qualify for the Medically Needy category will *not* be eligible for Transitional Medical services.

The proposal would also require some families to pay a share of cost each month in order to obtain their Medi-Cal health care coverage. Families currently enrolled in the 1931 (b) program have no share of cost. Under the Administration's proposal families with incomes above 75 percent of poverty would have to pay a share of cost.

The proposal would also add additional complexity to Medi-Cal eligibility determinations. Changes to county computer systems, as well as county eligibility worker training, would be needed to implement this proposal. However the Administration's cost estimate does not take this into consideration.

The Administration's proposal would deny health care coverage through the Medi-Cal Program to hundreds of thousands of low-income, working families. These are families which are low-income, *not* receiving cash-assistance, and who need health care coverage because their employers do not provide it.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please briefly explain your proposal and specifically whom would be affected by it.**
- **2. Please explain how the 1931 (b) issue interacts with the Healthy Families Parent Waiver expansion.**

ISSUE "3-C"—Roll Back the Aged, Blind and Disabled Eligibility *(See Hand Out)*

Background: The Budget Act of 2000 **extended "no cost" Medi-Cal eligibility to Aged, Blind and Disabled individuals with incomes up to 133 percent of federal poverty. These individuals have low-incomes but either do *not* qualify for, or choose not to participate in, the SSI/SSP Program.** Currently, individuals can have income of up to $969 per month and couples can have income of up to $1,332 per month and qualify for "no cost" Medi-Cal.

Governor's Proposed Budget: The **Administration proposes to roll this expansion back to cover only those eligibles with income up to the SSI/SSP income level or $708 per month for an individual (96 percent of poverty) and $1,225 per month for a couple (123 percent of poverty). The budget assumes savings of $127.6 million ($63.8 million General Fund) by eliminating 48,302 aged individuals and 20,538 disabled individuals from "no cost" Medi-Cal.**

Many of these individuals could still obtain coverage under Medi-Cal but they all would need to pay a share-of-cost each month to receive services. This share-of-cost payment would of course be significant for people on fixed, low-incomes. **(The share-of-cost is the amount by which that individual's income or assets exceeds the applicable Medi-Cal limits.)**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly describe your proposal.
- **2.** Please describe what would be a typical share-of-cost for individuals to spend down to become eligible for Medi-Cal if this reduction is effectuated.

Budget Issue: Does the Subcommittee want to reject or adopt the proposal to reduce Medi-Cal eligibility?

ISSUE "3-D"—Rollback Second Year of Transitional Medi-Cal Coverage

Background and Governor's Proposed Budget: Effective October 1, 1998, California implemented a second year of Transitional Medi-Cal pursuant to trailer bill that accompanied the Budget Act of 1998. Federal Welfare Reform law requires a one-year minimum for coverage.

The second-year of coverage is a state-only program to encourage parents to seek employment and continue their Medi-Cal benefits until they can secure employer paid benefits.

The budget proposes to eliminate the state-only program, leaving the retention of one-year of transitional Medi-Cal coverage. On average 1,834 monthly eligibles are expected to be discontinued. The budget assumes savings of almost $2 million (General Fund) for this purpose.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to briefly explain their proposal.

Budget Issue: Does the Subcommittee want to reject or adopt the proposal?

4. Administration's Proposal to Establish Standards for Medi-Cal Processing *(See Hand Out)*

Background: The state has not provided full funding for Medi-Cal county administrative functions for at least the past two years. For 2002-2003, county administrative funding was reduced by six percent. As a result of the reduced staffing counties are not able to meet statutory performance requirements. Among other things, annual re-determinations have not been completed on time, increasing the Medi-Cal caseload. Further, some counties are not able to complete the initial Medi-Cal eligibility determinations within the 45 day requirement period.

Governor's Proposed Budget (See Hand Out): The Administration proposes **enactment of legislation which would establish standards for counties to meet regarding Medi-Cal eligibility determinations and redeterminations, and assumes that because of these new standards 563,135 Medi-Cal recipients, or almost 9 percent of the eligibles, will be terminated from enrollment for savings of $388 million ($194 million General Fund) in local assistance**.

The proposal also requests an increase of $896,000 ($448,000 General Fund) for state support to fund 9 positions to oversee the counties activities and to measure their performance.

Initial trailer bill legislation obtained from the Administration would establish county performance standards in several areas, including:

- **Meet the 45 day requirement to complete eligibility determinations:**
  - 90% of all applications not specified below without significant applicant errors must be completed within 45 days.
  - 99% of all applications not specified below without significant applicant errors must be completed within 60 days.
  - 90% of applications with applicant errors must be completed within 60 days, exclusive of the time the applicant has the application for correction of applicant errors.
  - 99% of the applications with applicant errors must be completed within 75 days, exclusive of the time the applicant has the application for correction of applicant errors.
  - 90% of the applications for disability must be completed within 90 days.
  - 99% of the applications for disability must be completed within 105 days.
  - 90% of the newborn referral requests and the applications for pregnancy must be completed within 5 days
  - 99% of the newborn referral requests and the applications for pregnancy must be completed within 10 days.
- **Perform timely annual re-determinations:**
  - 90% of the annual re-determinations must be done by the end of the 13th month after initial application or anniversary date
  - 99% of the annual re-determinations must be done by the end of the 14th month after initial application or anniversary date

All of these processes would need to be completed within specified timeframes as noted in the legislation or a county may, at the department's discretion, have their Medi-Cal county administration allocation reduced by two percent in the following year. The performance standards are noted below:

In order to facilitate the counties meeting these proposed performance standards, the budget provides an increase of $152.1 million ($76 million General Fund) over two years, including $54.9 million for 2002-03 and $97.2 million for 2003-04.

The Administration contends that this adjustment would provide "full funding" for the counties to meet this potential obligation. The County Welfare Directors Association (CWDA) does not concur that this would be "full funding".

Constituency Concerns: As presently crafted, constituency groups are very concerned with the Administration's proposal for **they contend it has *several shortcomings*, including (1)** not being consistent with federal law and state mandates, **(2)** basing performance solely on caseload decline, and not considering appropriate caseload enrollment (including enrollment of eligible infants), **(3)** not offering to provide access to performance standards data so stakeholders can also access performance, and **(4)** not offering fiscal incentives to complete the standards effectively (only offers disincentives).

Subcommittee Staff Comment: Further **detailed discussions need to occur** in order to recast the proposal to make it more equitable to fully address Medi-Cal enrollment standards, not just disenrollment, to appropriately fund county administration, and to further clarify the standards in the context of federal law requirements. **This is a complex topic that needs substantially further work prior to any codification and budget action.**

As such, it is recommended for the Subcommittee to direct Subcommittee staff to work with constituency groups and the Administration to craft a potential compromise proposal.

Subcommittee Request and Questions: The Subcommittee **has requested the DHS and County Welfare Directors to respond to the following questions:**

- **1.** DHS--Please describe your proposal and why standards are needed.
- **2.** DHS--**Do *all* of the standards** the DHS proposes **comply with federal law and regulation?**
- **3.** CWDA—Please describe the Medi-Cal enrollment process from the viewpoint of a County Eligibility Worker.
- **4.** CWDA—Please provide your perspective on potential improvements to this proposal.

Budget Issue: Does the Subcommittee want to direct Subcommittee staff to work with constituency groups to craft a proposal to

5. Proposed Elimination of 18 Medi-Cal "Optional" Benefits—ISSUES "A" to "C"

Background Overall—What are Optional Benefits: The term **"Optional Benefits" is in reference to how federal law and regulation defines the service.** Under federal law, **certain medical services are required to be provided by states while others are provided at the state's "option"**. **The federal government mandates 13 services including:** inpatient hospital (excluding mental disease), outpatient hospital including certain clinics, physicians' services, pregnancy related services, X-Ray, laboratory testing, nursing home and home health care, family planning, and a few others.

In addition to those listed in the *chart below* (under the Governor's proposed budget), other "Optional Benefits" include: **Pharmaceuticals, Inpatient Psychiatric Services for adolescents under age 21, as well as several others.**

As noted in *Health Affairs* (volume 22, number 1, 2003), the comprehensive nature of Medicaid benefits is often misunderstood. The breadth of covered services reflects the complex needs of the disabled, aged, blind, mentally ill, medically needy children and pregnant women populations. Medi-Cal only reimburses for those "optional" services that are provided to individuals as a service.

Background Overall—Summary of California's Benefit Utilization Controls: Medi-Cal **covers medically necessary** health care services set forth in both federal and state law and regulation. **A Medi-Cal covered service must:**

- **Be adequate in amount, duration, and scope** to reasonably achieve its purpose;
- **Not vary based solely on a recipient's diagnosis, type of illness, or condition**; and
- **Be offered throughout the state** (referred to as "statewideness").

A service is "medically necessary" or deemed to be a "medical necessity" when it is reasonable and necessary to (1) protect life, (2) prevent significant illness or significant disability, or (3) alleviate severe pain.

The DHS states that **they determine "medical necessity" in three stages:**

- **Prior authorization**—i.e., before the service is rendered;
- **Prior to payment**—after the service is rendered but prior to payment; and
- **After payment**

Medi-Cal also employs **various utilization controls and review methods**, including:

- **Special utilization limits, which restrict the number of services a beneficiary may receive per month; and**
- **Restrictions on recipients found to be abusing the program.**

All inpatient hospital (except for obstetrical services of defined length mandated under state law), nursing facility, and Intermediate Care Facility (ICF) stays, require prior authorization and/or concurrent authorization.

California has a "Superior Systems Waiver" which describes the Medi-Cal Program's prior authorization process **for acute care hospital in-patient stays.** The DHS notes that the federal CMS recognizes that California's approach **under this Waiver is in fact, better than otherwise required under federal methodology.**

Many **outpatient services also require prior authorization**; these include the following:

- Certain out-patient hospital services;
- Certain Early Periodic Screening Diagnostic and Treatment Services (for full-scope Medi-Cal eligibles under age 21);
- Home Health Agency Services; and
- Allied Health services, including but not limited to—podiatry, chiropractic, optometry, occupational therapy, speech therapy, hearing aids, durable medical equipment, medical supplies, incontinence supplies over $165 per month, hospice, adult day health care, non-emergency medical transportation.

Certain services are reviewed through the claims approval process, including but not limited to:

- **Physician services**—subject to hundreds of edits and audits that limit payment including the number of high level (cost) visits a physician can bill for a patient;
- **Some laboratory, X-ray, and diagnostic testing services**; and
- **Medi-Cal's prepayment edits and audits** have been compared to those offered by commercial packages and done in other states. The DHS maintains that California has one of the **most extensive sets of edits and audits in the nation.**

Medi-Cal payments are also subject to extensive review after the claims are adjudicated. The DHS states that **pre-check write reviews** are performed to quickly detect mis-billing or fraud patterns. Payments are further reviewed by both the Audits and Investigations Division of the DHS and the State Controller.

Governor's Proposed Budget—Eliminate 18 Optional Benefits: The Administration proposed legislation effective April 1, 2003 to eliminate eight Medi-Cal Optional Benefit categories as part of the Governor's Mid-Year Reduction process for savings of $126.5 million ($63.3 million General Fund). This action was not taken.

For the budget year, ten additional benefits are slated for elimination for a total of 18 benefits for savings of $723.7 million ($361.8 million General Fund). These reductions are outlined in the table below.

Optional Benefit Category (Proposed to Eliminate)	**2002-03 Mid-Year Proposal** (April 1, 2003) (General Fund Savings)	**2003-04 Governor's Proposed** (General Fund Savings)
Adult Dental Services	$48.5 million	$211.8 million
Medical Supplies (diabetic supplies, IV supplies, wound care, asthma supplies, contraceptive supplies)	12.9 million	54.3 million
Van Transportation		31.5 million
Hospice		13.7 million
Durable Medical Equipment		12.5 million
Optician and Laboratory Services		14.5 million
Optometry		9.2 million
Podiatrist	995,000	4.3 million
Acupuncture	666,000	2.9 million
Prosthetics		2.1 million
Hearing Aids		2.9 million
Psychologist	57,000	229
Chiropractor	100,000	399
Independent Rehabilitation Facility	5,000	23
Occupational Therapy	4,000	15
Physical Therapy		30
Orthotics		640
Speech and Audiology		728
TOTAL GF SAVINGS	**$63.3 million**	**$361.8 million**

Subcommittee Staff Comment--Overall: Exempt from the proposal are services to children under 21 years of age and residents of long-term care facilities. Federal law precludes the elimination of these services from these individuals.

However, individuals with developmental disabilities would not be exempt from the Administration's proposal. As such, it is likely that Regional Centers would need to purchase these benefits for consumers at 100 percent General Fund expenditure, in lieu of obtaining partial matching federal funds. **Based on information just obtained from the Administration, an increase of $61.1 million General Fund will be needed for the Regional Centers in order to provide coverage for the 18 Optional Benefits if they are eliminated from the Medi-Cal Program. In addition, costs are still being calculated as to the potential affect on individuals residing in the state-operated Developmental Centers.**

As noted above, the three categories of adult dental services, medical supplies and van transportation (i.e., non-emergency medical transportation) account for over 80 percent of the proposed savings.

Legislature's Historical Rejection of Proposal: Elimination of selected Medi-Cal Optional Benefits has been proposed on six prior occasions—1990, 1992, 1993,1994, 1995 and 2001. **Even during these difficult fiscal times, the proposal was denied by the Legislature.**

ISSUE "5A"—Elimination of Adult Dental Services

Background—the "Denti-Cal" Program Overall: Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. **Access to dental services for children under age 21 is required by federal law; whereas Adult Dental services are considered "optional".**

Over 90 percent of Medi-Cal recipients are eligible for fee-for-service care through the Denti-Cal Program. In addition, a few individuals—about 350,000 or so—receive dental services through managed care arrangements (including some areas of Sacramento, San Bernardino, Riverside and Los Angeles). **Currently, there are about 13,000 providers enrolled in the Denti-Cal Program.**

Generally, covered dental benefits for children and adults include: (1) diagnostic and preventive services such as examinations and cleanings, **(2)** restorative services such as fillings and **(3)** oral surgery services. **Many services, such as crowns, dentures and root canals require prior authorization. Certain other services, such as dental sealants, fluoride applications and limited orthodontic care are covered only for children under age 21.**

State law requires most Medi-Cal recipients to pay a co-payment for dental care. A $1 co-payment is required for services provided in a dental office a and a $5 co-payment is required for non-emergency care provided in an emergency room. **However, as contained in federal law, services cannot be denied to the recipient if a co-payment is not provided.**

It is also well recognized that the reimbursement rates currently paid under the Denti-Cal Program are very low—generally, about 40 to 50 percent of the usual and customary fee charged by dentists in California.

Background—Specific Denti-Cal Program Utilization Controls: In **addition to requiring prior authorization** (i.e., documentation to substantiate the medical condition and then DHS sanctioned approval of requested medical procedure) on numerous procedures as noted above, **the Denti Cal Program also has other utilization controls in place, include the following:**

- **Manual review** to determine if the procedure is needed or if it was done at all. This review can include: medical necessity (x-rays, documentation and study models), longevity (x-rays), arch integrity (x-rays), degree of difficulty to determine payment (x-rays or other documentation), and documentation of service to insure appropriate procedure paid.
- **Clinical pre and post-operative screenings** by Regional Screening Consultants to review for necessity, quality and actual delivery of services by direct examination;

- **Surveillance/Utilization Review System**—a separate unit which is used to determine quality of care, necessity of care and compliance with all standards and laws;
- **Frequently limitations** on certain services, such as once per lifetime on orthodontia, once per year for cleanings, as well as others;
- **Time limitations** (i.e., procedure allowed only after a specific length of time has elapsed from date of service of another procedure). For example, time limitations are in place for root planning and denture reline;
- **Procedure limitations** on dates of service. For example, two tissue conditioning procedures only prior to denture construction;
- **System edits** are used to detect and reject certain items. For example, when a tooth has been extracted so that other treatments can not be billed;
- **Similar procedures cannot be performed on the same date of service**. For example, when an extraction is done, the same tooth may not be billed for an emergency visit.

Background--Top Ten Procedures in Denti-Cal Program: The following chart displays the most common procedures by expenditure amount as provided under the Denti-Cal Program in calendar year 2001 (most recent actual data available).

Code #	Top Ten Procedures by Expenditure Amount	Medi-Cal Rate	Total Incidences 2001 Data	Total Dollars 2001 Data (rounded)
612	Two Surface Amalgam Restoration (re-filling of a cavity using silver)	$48	758,934	$36,366,000
452	Subgingival Curettage (deep cleaning)	$200	180,925	$36,076,000
653	Porcelain w/metal crown	$340	98,885	$33,538,000
645	Plastic Filling	$55	576,994	$31,677,000
050	Dental Prophylaxis (ages 13 and older)	$40	650,907	25,977,000
611	One Surface Amalgam Restoration	$39	666,911	$25,972,000
660	Full Cast Crown (gold)	$340	65,233	$22,136,000
010	Examination, Initial Episode of Treatment Only	$25	850,890	$21,211,000
513	Molar Root Canal Therapy	$330	57,123	$18,816,000
062	Topical application of fluoride (ages 6 to 17 years)	$40	472,202	$18,782,000

Pregnancy Related Dental Services: In the Budget Act of 2001, preventive periodontal services and periodontal treatment for pregnant women was added to the scope of Medi-Cal benefits because **it saves Medi-Cal funds by decreasing neonatal intensive care services. The Administration proposed this last year because it has been well documented that periodontal disease affects the embryo, often causing pre-term low birth weight babies. These services could not be provided if Adult Dental services are eliminated.**

Budget Act of 2002—Reduction: The Budget Act of 2000 provided increased funding to allow for up to two office visits and two dental cleanings per year, as done in employer-based

insurance. **However, the Budget Act of 2002 *rolled this back* by limiting adults to one cleaning per year and one office visit for savings of $7.8 million ($3.9 million General Fund).**

Governor's Proposed Budget: The budget **proposes to eliminate Adult Dental Services for savings of $423.6 million ($211.8 million General Fund). This proposed savings level assumes the following:**

- **Dental services to adolescents aged 21 and under are maintained**, as well as **services to individuals living in long-term care facilities (as required by federal law)**. **However,** since Adult Dental Services constitutes **over 80 percent** of the Denti-Cal Program, elimination of them **would most likely affect children's access to dental services because there would be fewer providers.**
- **About $221.9 million ($111 million General Fund) in expenditures, or about 35 percent of the Adult Dental costs, are assumed to be shifted to other services.** Though these other services are undefined, it can be generally assumed that these expenditures are shifted to emergency rooms, physician services, pharmacies and clinics due to the potential need to mitigate dental infections, pull teeth and treat dental pain.
- **No accounting of increased General Fund expenditures due to the need to continue to provide Adult Dental Services to individuals with developmental disabilities** who will need to receive these services through the purchase of services by the Regional Centers, as well as providing services in the state-operated Developmental Centers.

  Based on recent information obtained from the Administration, it is estimated that an increase of about $19.7 million (General Fund) will be needed for the budget year to account for expenditures that will be incurred by the Regional Centers to fund this particular service. (This $19.7 million is a subset of the $61.1 million referenced above regarding the effect of eliminating all 18 Optionals on individuals with developmental disabilities). In addition, costs associated with individuals residing in state-operated Developmental Centers are still in the process of being calculated.

Constituency Concerns: The Subcommittee **is in receipt of numerous letters expressing concern** with the elimination of Adult Dental Services. These letters have included comments from professional organizations, various advocacy groups, family members with loved ones who have developmental disabilities and require specialized care, schools of dentistry, and various others.

Most of the letters express health concerns that note how ignoring oral health can lead to needless pain and suffering, causing significant complications to an individual's well-being. **For example, the absence of adequate oral health has been linked to oral cancer, heart disease, pre-term delivery and low-birth weight infants, stroke, diabetes, osteoporosis, and even lung disease.**

It is further noted that elimination of these benefits will most likely lead to additional costs to the health care system in physician visits and emergency room visits due to the interplay of oral and systemic relationships.

Subcommittee Staff Comment & Alternative Proposal: Adult Dental Services are ***core services*** needed to maintain a basic level of wellness. Yet due to the fiscal situation options for reducing costs should be presented. After reviewing the "top ten procedures" and reviewing areas where costs could be reduced without harm to patients, the following is **presented as an option for consideration. The items recommended below would save $50.750 million (General Fund) and would have a sunset date of two years in order to allow for a reassessment.**

- ***1. Use Stainless Steel Crowns in Lieu of Porcelain for Adults (not children) on Posterior Teeth:*** Based on recent data obtained from the DHS (for procedure codes 653 and 660), an **annual savings** of $31.7 million **($15.9 million General Fund)** could be achieved by substituting stainless steel crowns in lieu of porcelain for posterior teeth. In addition, require that pre-treatment x-rays be provided for verification of need for the crown.

- ***2. Limit Access for "Deep Cleanings" ($200-- procedure 452) to LTC/Institutionalized Individuals:*** According to the DHS, this procedure is performed almost exclusively on adults and is a frequently over utilized procedure by some practitioners. As such, it is recommended to limit this procedure to individuals residing in nursing homes or similar institutional settings. Based on data provided by the DHS, it is estimated that **a savings of about $34 million ($17 million General Fund) could be achieved.**

- ***3. Reinstate X-Rays for Cavities:*** According to the DHS, from 1973 to 1991 (pre-Clark v Kizer litigation), **the Denti-Cal Program required radiographs (x-rays) to be submitted along with the Medi-Cal claim before the provider was reimbursed.** When this requirement was eliminated, **expenditures for this procedure went up substantially—by as much as 40 percent—due to increased utilization.**

  Under this proposal, the filling can still be provided by the dentist at the time of the patient visit (i.e., this would not be a prior authorization process), but the submitted radiograph must clearly show that decay exists in order to receive payment. The Denti-Cal Program would inform providers not to fill a tooth that does not exhibit decay. **This would serve as a strong "anti-fraud" component as well.**

  If one assumed a **20 percent reduction** by reinstating the use of radiographs for cavity reimbursement, a savings of **about $33.2 million ($16.6 million General Fund)** could be achieved. **This change would apply to procedures for both adults and children.**

- ***4. Cost Savings from Re-Enrollment of Dentists into Medi-Cal:*** Through substantive statutory changes enacted through trailer bill language which accompanied the Budget Acts of 1999, 2000 and 2001, the DHS was provided with broad authority to, among other things, re-enroll Medi-Cal providers into the program as an anti-fraud measure**. The DHS is presently in the process of developing emergency dental regulations to proceed with the re-enrollment of Dentists, as well as with incorporating additional criteria to better assess one's "established place of business" (to deny unscrupulous providers enrollment).**

  No savings have been captured in the budget for this purpose for the DHS believes that additional resources are needed in order to implement. Specifically, **they contend that a**

total of $1.7 million ($570,000 General Fund) is needed to (1) increase funding for the Delta Dental Contract ($1 million total funds) to do provider enrollment (with state direction), (2) hire five DHS staff to conduct application reviews and background checks of providers, and (3) hire four audits and investigations staff to conduce re-enrollment inspections of provider applications, investigate suspected fraud schemes and related matters.

The DHS states that if these additional resources are provided, a savings of $3 million ($1.5 million General Fund) could be achieved in 2004-05, for a net savings of almost $1.3 million ($750,000 General Fund). The DHS states that savings for the re-enrollment of dentists would result in only a 5 percent savings (of the $60 million cost savings projections obtained from the health care side).

Subcommittee staff would recommend moving forward on the Dental Contract adjustment ($250,000 General Fund increase), and to temporarily redirect some DHS staff to commence with the dental provider enrollment in the budget year. It is the Subcommittee's staff belief that re-enrollment of dental providers will be more straightforward than that of re-enrolling some other provider groups. **As such, it is assumed that half of the estimated savings can be obtained in the budget year. Therefore, a *net* saving of $1.250 million (General Fund) is assumed.**

Subcommittee Request and Questions: The Subcommittee has requested **the DHS to respond to the following questions:**

- **1.** Please **briefly explain** some of the **existing control containment** strategies presently **used in the Denti-Cal Program.**
- **2.** Please **explain your proposal and the calculation used to determine the cost-shift aspect of the proposal**.
- **3.** Please **briefly explain the impact this proposed reduction would have on individuals with developmental disabilities.**
- **4. From a technical assistance standpoint, please comment on the above outlined staff recommendation.**

Budget Issue: Does the **Subcommittee want to (1)** direct Subcommittee **staff to further investigate options for reducing expenditures** for Adult Dental Services, **(2)** reject the Administration's proposal outright, ***or* (3)** adopt the Administration's proposal to eliminate this service?

ISSUE "5B"—Elimination of Medical Supplies

Background: The Medi-Cal Optional benefit category of **Medical Supplies** is very encompassing. It includes such **items as the following: incontinence supplies, diabetic supplies, catheters, needles and syringes, bandages, ostomy supplies gloves, urinary drainage supplies, feeding tubes, condoms, contraceptive creams and foams, diaphragms, vaporizers, breast pumps, nebulizer, and asthma supplies.**

Current statute and regulatory provisions establish the maximum reimbursement rates for medical supplies, incontinence medical supplies, durable medical equipment and prosthetic and orthotic appliances. **Generally, the methodology for establishing the maximum reimbursement rates for these products consists of adding the provider's established acquisition cost to an allowable percentage markup. This methodology was established under the assumption that providers operate under market conditions (acquire retail products from legitimate distribution channels in the open market). However, the DHS has found this not to be the case.**

As such, the DHS is proceeding with emergency regulation changes that enable the DHS to enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies or other product-type health care services.

In addition, **the Bureau of State Audits presented an analysis (December 2002, report 109) regarding suggestions and recommendations on how the DHS could better control the pricing of durable medical equipment and medical supplies.**

Governor's Proposed Budget: The budget proposes **elimination of Medical Supplies for savings of $108.6 million ($54.3 million General Fund).** This savings level assumes the elimination of benefits to all adults, except for those in long-term care. **As such, an increase in General Fund support of $15 million would need to be provided to the Regional Centers in order to appropriately fund individuals with developmental disabilities who require these services.** (This General Fund figure is a subset amount of the $61.1 million as referenced above.) **Next to Adult Dental Services, this is the largest Optional Benefits category being proposed for elimination.**

Constituency Concerns: The Subcommittee is in receipt of numerous letters requesting the Subcommittee to reject the Governor's proposal and to retain the benefit.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please provide a brief description of your proposal.**
- **2. Would elimination of Medical Supplies also affect the Family PACT Program?**
- **3. How would individuals with developmental disabilities be potentially affected?**
- **4. Please briefly explain the emergency regulations for medical supplies. Could the DHS potentially use contracts more and obtain Medical Supplies at reduced costs?**

- **5. Please provide an update on how the DHS is responding to concerns raised by the Bureau of State Audits in their analysis. From a technical assistance standpoint, could more be done? Please be specific.**

Budget Issue: Does the **Subcommittee want to direct the DHS and Subcommittee staff to report back on other options for reducing expenditures for Medical Supplies prior to any elimination of said benefit?**

ISSUE "5C"—Elimination of The Other 16 Optional Benefits

Governor's Proposed Budget: Listed below are the additional Optional Benefits the Governor has proposed for elimination. Exempt from the proposal are services to children under 21 years of age and residents of long-term care facilities. Federal law precludes the elimination of these services from these individuals.

Optional Benefit Category	2002-03 Mid-Year Proposal (April 1, 2003) (General Fund Savings)	2003-04 Governor's Proposed (General Fund Savings)
Van Transportation		31.5 million
Hospice		13.7 million
Durable Medical Equipment		12.5 million
Optician and Laboratory Services		14.5 million
Optometry		9.2 million
Podiatrist	995,000	4.3 million
Acupuncture	666,000	2.9 million
Prosthetics		2.1 million
Hearing Aids		2.9 million
Psychologist	57,000	229,000
Chiropractor	100,000	399,000
Independent Rehabilitation Facility	5,000	23,000
Occupational Therapy	4,000	15,000
Physical Therapy		30,000
Orthotics		640,000
Speech and Audiology		728,000
TOTAL GF SAVINGS	**$1.8 million**	**$95.7 million**

Constituency Concerns: The Subcommittee is in receipt of numerous letters regarding the potential loss of these services. Van transportation is a primary mode of transportation for patients needing dialysis. Patients need wheelchairs, hearing aids, prosthetic devices, glasses, and rehabilitation-oriented services. Many of these services are needed in order to ameliorate a chronic condition so it does not get progressively worse.

As noted previously, **Regional Centers that provide services to individuals with developmental disabilities would need substantially increased funding** (total of $61.1 million

General Fund for all 18 Optional Benefits) in order to provide these services if Medi-Cal does note.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly explain** your proposal.
- **2.** How would **individuals with developmental disabilities be affected**?
- **3.** If these services were eliminated, how would a Medi-Cal recipient potentially obtain the needed service?
- **4.** From a technical assistance basis, **are there any potential cost containment measures that could be instituted for any of these services to reduce expenditures?**

Budget Issue: Does the Subcommittee want to direct Subcommittee staff to develop options for cost containment for some of these services?

6. Proposal to Reduce Medi-Cal Rates by 15 Percent *(See Hand Out)*

Governor's Proposed Budget: The Administration proposed legislation to **reduce *both* Medi-Cal *and* Non-Medi-Cal provider rates by 10 percent across-the-board effective April 1, 2003** to achieve savings of $479.3 million ($90.4 million General Fund) within the Medi-Cal Program for 2002-03, **and by a total of 15 percent for 2003-04 to achieve savings of $1.428 billion ($720.5 million General Fund) within the Medi-Cal Program for 2003-04**. The **legislation would continue the reduction for three years through 2005-06 (ending as of July 1, 2006).**

This is the first time that an across-the-board rate reduction has been proposed. For Medi-Cal providers, the rate reduction includes nursing home facilities, Intermediate Care Facilities for Developmentally Disabled (ICF-DD), physician services, pharmacy, dental services, managed care plans, home health, medical transportation, and other medical services.

The rate reduction also includes **Non-Medi-Cal programs**, including the California Children's Services (CCS) Program, the Family Planning, Access, Care and Treatment Program (Family PACT), the State-Only Family Planning Program, the Genetically Handicapped Persons Program, and the Breast and Cervical Cancer Early Detection Program. ***(These proposed rate reductions will be discuss at a later Subcommittee hearing in April.)*** **The proposed trailer bill legislation would also provide the Director of the DHS authority to identify in regulations *other* programs in which providers shall be paid rates of payment that are identical to the rates paid under Medi-Cal.**

The following table summarizes the rate reduction affect to Medi-Cal Programs for 2003-04.

Medi-Cal Service Category	**2003-04** **Governor's Proposed** **(July 1, 2003)** **(15 percent)** **(General Fund Savings)**
Nursing Home Facilities (including ICF-DD)	$253.2 million
Managed Care Plans	211.5 million
Physicians Services	76.6 million
Other Services (adult day health, hospice, hearing aids, AIDS waiver, and others)	46.3 million
Other Medical Services (podiatry, occupational therapy, acupuncture and others)	30.1 million
Pharmacy Services	23.7 million
ICF-DD Facilities	30.4 million
Dental Services	23.8 million
Home Health	13 million
Early Periodic Screening Diagnostic and Treatment (EPSDT) Services	2 million
Medical Transportation	9.8 million
TOTAL SAVINGS	**$720.5 million**

Exempt from the reduction are: hospital inpatient services, hospital outpatient services, state operated facilities—i.e., Developmental Centers and State Hospitals for the mentally ill—, and Federally Qualified Health Centers/Rural Health Centers. Hospital inpatient services are exempt since the state negotiates inpatient services through the CMAC, and hospital outpatient services are addressed in the Orthopaedic Settlement Agreement. Federal law prohibits an across-the-board rate reduction for FQHC/RHC facilities since a cost-based or prospective payment system is used.

In the Budget Act of 2000, most services provided under Medi-Cal received rate adjustments. This action was not an across-the-board rate increase, but instead targeted services for which Medi-Cal physician rates were relatively low in comparison to the Medicare Program. Generally, other than annual adjustments for nursing home rates, there had not been a rate increase for most Medi-Cal services prior to the Budget Act of 2000 since 1986.

Sub committee Staff Comment: There is evidence that the rates paid to providers could affect access to health care and the quality of care to patients. A recent national analysis of Medicaid physician rates by The Urban Institute concluded that physician fee levels affect both access and outcomes for Medicaid patients.

A Pricewaterhouse study completed last year found that, even after accounting for the rate increase provided in 2000, Medi-Cal rates continue to lag behind those of other purchasers of health care coverage in California. Another study released last year found that while the 2000 Medi-Cal rate increases were substantial, they collectively only brought the Medi-Cal provider rates from 58 percent to 65 percent of California's average Medicare payment rates.

This is the first time that nursing home facilities have been included in a rate reduction. Inclusion of nursing homes, **particularly ICF-DD facilities** (almost 100 percent Medi-Cal based), is particularly problematic due to staffing standards and wage requirements, federal regulations, and the industry's dependence on Medi-Cal payments (two-thirds of the over 1,500 nursing homes depend on Medi-Cal reimbursement). In addition, a State Plan Amendment would be required since the federal government requires these rates to be developed on an annual basis through a methodology contained in the state's Medicaid State Plan.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly describe the proposal.
- **2.** Why were nursing homes, including ICF-DD facilities, included in the rate reduction?

Budget Issue: Does the Subcommittee want to modify or adopt the proposal?

7. Proposed Elimination of the Supplemental Wage Payment for Long-Term Care *(See Hand Out)*

Background and Governor's Budget Proposal (See Hand Out): Through the Budget Act of 2001 and accompanying trailer bill legislation, an appropriation was provided to serve as a supplemental wage adjustment for long-term care facilities which have a collective bargaining agreement or contract to increase salaries, wages, or benefits for certain staff. Under this proposal, participating providers needed to provide proof of a binding written commitment and a method of enforcement of the commitment. **The program was intended to terminate when the DHS implemented a facility-specific reimbursement methodology for non-hospital based nursing facilities (i.e., freestanding facilities).**

It should be noted that the Supplemental Wage Payment has *never* been allocated to the facilities.

The budget proposes to eliminate funding for this proposal for savings of $42 million ($21 million General Fund). This level represents what the updated amount would be if allocated.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Why has the **Supplemental Wage Payment never been implemented?**
- **2. What would it take to implement?**
- **3.** Please step through the Administration's proposal trailer bill language.

Budget Issue: Does the Subcommittee want to adopt or deny the Administration's proposal?

8. Quality Assurance Fee for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD Facilities)

Background—What Are ICF-DD Facilities and How are They Paid: Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) are health facilities licensed (state requirements) and certified (federal requirements) by the Department of Health Services to **provide 24-hour per day care**. **Generally, ICF-DD facilities provide assistance to individuals with significant medical needs.**

Based on information provided by the DHS, there are a total of **964 ICF-DD facilities in California of which 957 are "privately-operated" facilities and seven are state-operated (i.e., the Developmental Centers).**

ICF-DD facilities are unique from other long-term care nursing facilities in that the clients who receive services are almost always enrolled in Medi-Cal. As such, there is no other third-party reimbursement available—the facility is reliant on Medi-Cal reimbursement.

According to the DHS, the average daily rate reimbursed by Medi-Cal is $166 per patient per day for privately-operated facilities and $524 per patient per day for the state-operated Developmental Centers.

Background--Governor's Proposed 15 Percent Reduction on Long-Term Care, including ICF-DD: The Administration is proposing to **reduce rates by 15 percent**, as discussed in Agenda Item 6, above. Under this scenario, privately-operated ICF-DD facilities **would receive a $141 per patient per day reimbursement. State-operated Developmental Centers would not have their rates reduced at all.**

Governor's Mid-Year Proposal—Denied Pending Clarification: As part of the Mid-Year Reduction package, the Administration proposed **to enact legislation** effective April 1, 2003 which **required ICF-DD facilities and state Developmental Centers to pay the state a Quality Assurance Fee of 6.5 percent.** The Legislature postponed enactment pending resolution of the Governor's proposed 15 percent Medi-Cal rate reduction (which includes ICF-DD facilities) and its impact on this proposal, as well as a need to clarify how Developmental Center rates would be affected.

Since this time, the Administration has had an opportunity to revise their proposal.

Revised Governor's Budget Proposal—Assessment Fee and Rate Reduction: The Administration is proposing to require ICF-DD facilities and state Developmental Centers **to pay the state a Quality Assessment Fee of 6 percent on the total rate per patient day. This assessment amount would then be used by the state to obtain a portion of federal matching funds. A portion of these new federal funds would be used to offset General Fund expenditures and to provide for a rate adjustment to ICF-DD facilities.**

The Quality Assessment Fee would be a per diem "add-on" to the regular reimbursement rate and would be added for each patient day during the quarter. **This add-on would be computed to return at least 100 percent of the fee paid by the facility at the end of the particular quarter.**

According to the Administration, if one assumes the 15 percent rate reduction *and* the 6 percent Quality Assurance Fee, a total net General Fund gain of $19.5 million can be obtained, or a savings of $1.7 million more than originally anticipated. (The Governor's January budget assumed a net gain of only $17.8 million). Of the $19.5 million amount, $12.4 million is attributable to the state Developmental Centers and $7.1 million is attributable to the privately-operated ICF-DD facilities.

It should be noted that the state-operated Developmental Centers would not be receiving any rate adjustment due to the Quality Assurance Fee proposal, nor are they subject to the proposed 15 percent long-term care rate reduction in Medi-Cal.

In addition to the need for statutory change, the state would need to submit a Medicaid State Plan amendment to the federal CMS for approval. **It should be noted that several other states have implemented similar programs for their ICF-DD populations.**

How Are Privately-Operated ICF-DD Facilities Affected by Administration's Proposal: The 6 percent Quality Assurance Fee would require **privately-operated ICF-DD facilities to pay an average daily fee of $8.46 per patient per day.** (This assumes that the average daily rate drops to $141 due to the 15 percent rate reduction; therefore, 6 percent of $141 equals $8.46.)

In return for this payment, the state would ensure that **each privately-operated ICF-DD facility received their Quality Assurance Fee payment back plus a portion of the federal fund amount** (i.e., **a net amount back or rate adjustment**). **According to the DHS, this net amount would equate to about 25 percent of the federal fund amount, or about a 1.9 percent rate adjustment across the board.**

In actuality, each facilities' rate adjustment would vary depending on the number of Medi-Cal patient days and patient occupancy.

Therefore according to the DHS calculations, instead of receiving a rate reduction of the across-the-board 15 percent, privately-operated ICF-DD facilities would experience on

average a 13.07 percent rate reduction (due to the interaction of the Quality Assurance Fee).

Constituency Concerns: Constituency groups **are interested in enacting the Quality Assurance Fee, though concerns with the 15 percent rate reduction cannot be ignored.**

Among other issues, the industry is **seeking to modify trailer bill language to make it clear that ICF-DD providers must receive a rate adjustment before they can pay the Quality Assurance Fee to the state for the providers have no ability to "float" the state revenue.** They contend that their proposed language is needed in order to provide 100 percent of **the net** from the Quality Assurance Fee on privately-operated ICF-DD facilities back to the providers.

Subcommittee Request and Questions: The Subcommittee **has requested the DHS to respond to the following questions:**

- **1. Please provide a brief summary of the proposal.**
- **2. Please briefly walk-through the Administration's *revised* proposed trailer bill language**
- **3. Is it the intention of the Administration's proposal to pay for normal rate items, or are these funds to be used for quality improvement? Please explain.**

Subcommittee Staff Comment: Many states use the quality assurance fee concept and have been obtaining increased federal funds for many years through this process. **It meets all federal law requirements and provides assistance to facilities, as well as to the state. As such, it is recommended to adopt the proposal including the revised trailer bill language (as placeholder language until final technical adjustments are made). (This proposal should be treated separate and apart from the 15 percent rate discussion.)**

Budget Issue: Does the **Subcommittee want to adopt the Administration's proposal in concept and direct Subcommittee staff to work with the Administration and constituency groups to finalize the trailer bill language?**

9. Proposed Implementation of New Controls on Selected Services *(See Hand Out)*

Governor's Proposed Budget: The budget proposes **to implement new utilization and payment controls in the Medi-Cal Program for savings of $76 million ($38 million General Fund).**

Specifically, the DHS is proposing the following four items which equate to this amount:

- ***A. Reduction of Medi-Cal Rates to 80% of Medicare Level for Laboratory Services ($20 million total) (See Hand Out for Trailer Bill Language):*** **An across the board rate reduction of the Medi-Cal rate to 80 percent or less than the current federal Medicare rate is being proposed.** The DHS **contends that $20 million ($10 million General Fund)**

can be obtained from this reduction. **It should be noted that any rate reduction must be done in concert with current laboratory contracting processes.**

The Administration **is proposing trailer bill language** to implement this provision. **(See Hand Out).**

Though authority was provided to the DHS to contract out for laboratory services in the omnibus health trailer bill (AB 442) of the Budget Act of 2002, contracting has not yet been implemented. The DHS states that it **will be initiating** contracts with laboratory providers in **three phases—(1)** clinical laboratories (not affiliated with either hospitals or clinics) that perform moderate and/or high complexity tests, **(2)** physician and physician groups, and **(3)** clinical laboratories that are affiliated with clinics that perform moderate and/or high complexity tests. *(It should be noted that due to the Orthopaedic Settlement Agreement, hospital outpatient laboratory services will not be included as part of this proposed reduction.)* **The contracting language will require that contracted laboratories accept reimbursement at no more than 80 percent of Medicare reimbursement for each laboratory test.** Authority was provided to the DHS in AB 442, Statutes of 2002 (omnibus health trailer bill)

However, because the contracting process will take time to implement, the Administration wants to reduce reimbursement now, via statutory change.

- ***B. Rate Review and Adjustments ($35 million total) (See Hand Out for Trailer Bill Language):*** The **DHS intends to methodically research and eliminate obsolete Medi-Cal codes that are currently reimbursed.** In theory, legitimate providers may still accidentally bill for such procedures, or unscrupulous providers are doing so fraudulently. **These codes may be obsolete due to medical advances such as medications, products, or equipment that is no longer manufactured, or physician procedures that are no longer in practice.** For example, the elimination of payment for services not medically justified such as elastic stockings as a Medi-Cal benefit. **The budget assumes savings of $35 million ($17.5 million General Fund) from this process.**

- ***C. Procedure Code Restriction ($16 million total) (See Hand Out for Trailer Bill Language):*** The DHS **intends to limit a provider's ability to cause secondarily referred services to be billed by a physician, pharmacy, laboratory, or durable medical equipment provider**. The DHS contends that they have observed cases where a non-Medi-Cal provider has been administratively sanctioned or banned from the Medi-Cal Program yet is still causing the downstream occurrence of a large amount of paid claims through deferrals, prescriptions, or requisitions. Current sanction's do not limit a provider's ability to refer patients to other non-sanctioned providers. As a result, direct payments to the providers in question may cease, but payments made on behalf of their actions (i.e., referrals to other providers) may continue or actually increase. **The budget assumes savings of $16 million ($8 million General Fund) for this purpose.**

- ***D. Link Reimbursement to Net Purchase Price of Products ($5 million total):*** The DHS requires that Medi-Cal billings by providers for medical supplies, incontinence supplies, durable medical equipment and prosthetic and orthotic appliances be based on the net purchase price of these products, not the estimated acquisition cost or the weighted average cost of the negotiated contract price which both presume operation of market conditions. Therefore, the DHS intends to link reimbursement to the net purchase price of these products through an audit process. **They estimate savings of $5 million ($2.5 million General Fund) from this proposal.**

Subcommittee Staff Recommendation: Due to the existing fiscal situation, it is recommended to adopt these proposals in concept and to work with constituency groups regarding any potential adjustments to trailer bill language.

Subcommittee Staff Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please explain *each* component of your proposal.**
- **2. Do any of these proposals require statutory change? If so, please explain.**
- **3. Since no additional DHS staff have been requested for this purpose, it is assumed that none are needed. Is this correct?**

Budget Issue: Does the Subcommittee want to adopt or modify the Administration's proposal?

LAST PAGE OF AGENDA